Report to

Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services
and
the Governor
and each
Board of County Commissioners

on

Area Authority/County Program Catchment Area Consolidation Plan

as required by
Session Law 2001-437, Section 3(a) 8, House Bill 381

February 14, 2005

Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
Department of Health and Human Services

Area Authority/County Program Catchment Area Consolidation Plan

Section 3 (a) (8) of HB 381, An Act to Phase in Implementation of Mental Health System Reform at the State and Local Level, requires the Secretary of the Department of Health and Human Services to develop a catchment area consolidation plan. The legislation calls for the Secretary to develop a plan that results in a "target of no more than 20 area authorities and county programs." In doing so, the legislation directs the Secretary to consider the letters of intent received from boards of county commissioners, the capacity of programs to implement the business plan, and "geographic and population targeted thresholds" in developing the plan. The completed plan is to be submitted to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services, the Governor, and each board of county commissioners.

The North Carolina Association of County Commissioners and the North Carolina Council of Community Programs were consulted in the preparation of this report.

I. Consolidations to Date

The functions to be performed by Area/County Programs as managers of services at the local level are very different from the functions that the programs previously performed as service providers. As Area Authorities developed and started to implement their local business plans, some small to mid-size programs came to an immediate understanding of the importance of the cost efficiencies and economies of scale, as well as the increased staff expertise, that could be gained through consolidation of programs. Those programs began immediate conversations with potential partners.

In July of 2003, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services held a meeting with the Directors of Area Authorities that did not meet the target geographic or population threshold and the County Managers of the counties in those programs' catchment areas. The purpose of the meeting was to discuss the identified obstacles to and potential benefits of consolidation.

As a result of that meeting, subsequent individual discussions, and Area Authority-initiated activities, several programs have already merged or are actively engaged in the process of merging.

When HB 381 was ratified the State was served by 40 Area Authorities. As of July 1, 2005 that number has been reduced to 33 and by July 1, 2006 will be reduced to 28 through these voluntary consolidations.

The programs that have completed or are engaged in consolidation activities currently are:

Consolidated Program	Programs Consolidated	Counties Served
1. Completed Consolidations:		
Eastpointe	Duplin-Sampson, Lenoir, Wayne	Duplin, Lenoir, Sampson, Wayne
Piedmont	Piedmont, Davidson	Cabarrus, Davidson, Rowan, Stanly, Union
Western Highlands	Blue Ridge, Rutherford-Polk, Trend	Buncombe, Henderson, Madison, Mitchell, Polk, Rutherford, Transylvania, Yancey
2. Partially Completed Consolidations:		
Sandhills (Sandhills/Randolph complete, Lee-Harnett 7/1/2005)	Sandhills, Randolph, Lee-Harnett	Anson, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, Richmond

Consolidated Program	Programs Consolidated	Counties Served
3. Pending Consolidations		
(Not yet named)	Alamance-Caswell, Rockingham	Alamance, Caswell, Rockingham
Onslow/Carteret Behavior Healthcare	Onslow, portion of Neuse	Carteret, Onslow
(Not yet named)	Roanoke-Chowan, Tidelands	Beaufort, Bertie, Gates, Hertford, Hyde, Martin, Northampton, Tyrell, Washington
(Not yet named)	Edgecombe-Nash, Wilson-Greene	Edgecombe, Greene, Nash, Wilson
(Not yet named)	VGFW, Riverstone	Franklin, Granville, Halifax, Vance, Warren

II. Programs Below the Geographic and Population Targeted Thresholds

With the completion of the voluntary consolidations outlined above, only four (4) Area Authorities will not meet the minimum five (5) county or 200,000 population thresholds. Three of those are single county Area Authorities serving Catawba, Johnston and Pitt counties. The other is a multi-county program, Neuse, serving Craven, Jones and Pamlico counties (as of July 1, 2005 when Carteret Counties leaves the Neuse Area Authority to merge with Onslow County). Only the Neuse program is actively seeking a potential merger partner at this time. The projected population of the catchment area of those programs at July 1, 2005 is outlined below.

Program	July 1, 2005 Population
Catawba County	151,169
Johnston County	145,240
Neuse Area Authority	117,614
Pitt County	143,158

Pitt and Neuse are contiguous programs. A consolidation between them would result in a program that met the 200,000 population threshold. With the mergers that are already in process, there are not programs contiguous to either Catawba or Johnston that do not already exceed the minimum target population threshold.

III. Consolidation Plan

If each the four (4) programs that do not meet the target threshold consolidated with one other program, the total number of area authorities/county programs would be reduced to 24. In order to reduce to 20 programs, some programs that already exceed the geographic and population thresholds would have to consolidate. The DHHS believes that partnerships have the greatest possibility of success if they are entered into voluntarily. Merging programs is a significant undertaking, as the programs that have already merged can verify. Simply dealing with all of the personnel issues, such as different fringe benefit packages and personnel policies, can be a daunting task. In addition, merging programs must develop new policies and procedures for all LME functions, consolidate data, which often involves purchasing and implementing new computer systems, and work to build relationships with local government officials and partner agencies in the new, consolidated catchment area.

In recognition of the significant changes currently taking place in the public mental health, developmental disability, and substance abuse services system – transition of service delivery from the Area Authorities to other public and private providers, direct enrollment in the Medicaid program for all providers, implementation of new service definitions and benefit packages that reflect evidence-based best practice, implementation of person centered planning for all disabilities, requirement for increased involvement by consumers and family members in the service delivery

system, etc. – we do not believe that it would be possible or prudent at this time to force the consolidation of programs that do not choose to merge voluntarily. In taking this position, we also note that the reform legislation gave counties the option of choosing to operate a single county program, regardless of population size (G.S. 122C-115.1), which limits the ability of the DHHS to force mergers of single county programs.

We believe that as programs continue to evolve into Local Management Entities some of the programs that have been resistant to consolidation thus far may conclude that it is not practical or effective to remain autonomous. However, the DHHS also recognizes that there are issues other than geographic or population size which can affect the ability of a program to fulfill its obligations as a LME and that there are other factors than consolidation that may address cost efficiencies. The three (3) single county programs listed above receive significant infrastructure support from their county government such that they do not require the level of State funding to support LME functions that a freestanding area authority of the same size might require. In addition, LMEs are beginning to discuss other means of creating economies of scale and increased efficiency by collaborating in certain expenditures or LME function, without entering into full, formal mergers.

The DHHS will continue to work with Area/County Programs to address opportunities for cost efficiencies, including opportunities for consolidation. At the same time, through the performance-based contact, we will continue to increase the outcomes that programs must achieve. We believe that these combined activities will result, over time, in the "right sizing" of the community system, without the need to force consolidations.